

(A) The portion of the hospital subject to the prospective payment system.

(B) The outpatient department of the hospital.

(C) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities under an approved medical residency training program is counted towards the determination of full-time equivalency if the criteria set forth at § 413.86(f)(1)(iii) are met.

(iii) Full-time equivalent status is based on the total time necessary to fill a residency slot. No individual may be counted as more than one full-time equivalent. If a resident is assigned to more than one hospital, the resident counts as a partial full-time equivalent based on the proportion of time worked in any of the areas of the hospital listed in paragraph (g)(1)(ii) of this section, to the total time worked by the resident. A part-time resident or one working in an area of the hospital other than those listed under paragraph (g)(1)(ii) of this section (such as a freestanding family practice center or an excluded hospital unit) would be counted as a partial full-time equivalent based on the proportion of time assigned to an area of the hospital listed in paragraph (g)(1)(ii) of this section, compared to the total time necessary to fill a full-time internship or residency slot.

(iv) Effective for discharges occurring on or after October 1, 1997, the total number of full-time equivalent residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting that meets the criteria listed in paragraph (f)(1)(ii) of this section may not exceed the number of such full-time equivalent residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996.

(v) For a hospital's cost reporting periods beginning on or after October 1, 1997, and before October 1, 1998, the total number of full-time equivalent residents for payment purposes is equal to the average of the actual full-time equivalent resident counts (subject to the requirements listed in paragraphs

(f)(1)(ii)(C) and (f)(1)(iv) of this section) for that cost reporting period and the preceding cost reporting period. For a hospital's cost reporting periods beginning on or after October 1, 1998, the total number of full-time equivalent residents for payment purposes is equal to the average of the actual full-time equivalent resident count (subject to the requirements listed in paragraphs (f)(10)(ii)(C) and (f)(1)(iv) of this section) for that cost reporting period and the preceding two cost reporting periods.

(2) To include a resident in the full-time equivalent count for a particular cost reporting period, the hospital must furnish the following information. The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program.

(i) A listing, by specialty, of all residents assigned to the hospital and providing services to the hospital during the cost reporting period.

(ii) The name and social security number of each resident.

(iii) The dates the resident is assigned to the hospital.

(iv) The dates the resident is assigned to other hospitals or other freestanding providers and any nonprovider setting during the cost reporting period.

(v) The proportion of the total time necessary to fill a residency slot that the resident is assigned to an area of the hospital listed under paragraph (g)(1)(ii) of this section.

(3) Fiscal intermediaries must verify the correct count of residents.

(g) *Indirect medical education payment for managed care enrollees.* For portions of cost reporting periods beginning on or after January 1, 1998, a payment is made to a hospital for indirect medical education costs, as determined under paragraph (e) of this section, for discharges associated with individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act or with a Medicare+Choice organization under title XVIII, Part C of the Act during the period.

[50 FR 12741, Mar. 29, 1985. Redesignated at 56 FR 43241, Aug. 30, 1991]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.105, see the List of Sections Affected in the Finding Aids section of this volume.

**§ 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.**

(a) *General considerations.* (1) The factors considered in determining whether a hospital qualifies for a payment adjustment include the number of beds, the number of patient days, and the hospital's location.

(i) The number of beds in a hospital is determined in accordance with § 412.105(b).

(ii) The number of patient days includes only those days attributable to areas of the hospital that are subject to the prospective payment system and excludes all others.

(iii) The hospital's location, in an urban or rural area, is determined in accordance with the definitions in § 412.62(f).

(2) The payment adjustment is applied to the hospital's DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs, excluding outlier payments for inpatient operating costs under subpart F of this part and additional payments made under the provisions of § 412.105.

(b) *Determination of a hospital's disproportionate patient percentage.* (1) *General rule.* A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.

(2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, HCFA—

(i) Determines the number of covered patient days that—

(A) Are associated with discharges occurring during each month; and

(B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation;

(ii) Adds the results for the whole period; and

(iii) Divides the number determined under paragraph (b)(2)(ii) of this sec-

tion by the total number of patient days that—

(A) Are associated with discharges that occur during that period; and

(B) Are furnished to patients entitled to Medicare Part A.

(3) *First computation: Cost reporting period.* If a hospital prefers that HCFA use its cost reporting period instead of the Federal fiscal year, it must furnish to HCFA, through its intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period.

(4) *Second computation.* The fiscal intermediary determines, for the hospital's cost reporting period, the number of patient days furnished to patients entitled to Medicaid but not to Medicare part A, and divides that number by the total number of patient days in that same period.

(5) *Disproportionate patient percentage.* The intermediary adds the results of the first computation made under either paragraph (b)(2) or (b)(3) of this section and the second computation made under paragraph (b)(4) of this section and expresses that sum as a percentage. This is the hospital's disproportionate patient percentage, and is used in paragraph (c) of this section.

(c) *Criteria for classification.* A hospital is classified as a "disproportionate share" hospital under any of the following circumstances:

(1) The hospital's disproportionate patient percentage, as determined under paragraph (b)(5) of this section, is at least equal to one of the following:

(i) 15 percent, if the hospital is located in an urban area and has 100 or more beds, or is located in a rural area and has 500 or more beds.

(ii) 30 percent, if the hospital is located in a rural area and either has more than 100 beds and fewer than 500 beds or is classified as a sole community hospital under § 412.92 of this subpart.

(iii) 40 percent, if the hospital is located in an urban area and has fewer than 100 beds.

(iv) 45 percent, if the hospital is located in a rural area and has 100 or fewer beds.

(2) The hospital is located in an urban area, has 100 or more beds, and can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to indigent patients.

(d) *Payment adjustment.* (1) *Method of adjustment.* Subject to the reduction factor set forth in paragraph (e) of this section, if a hospital serves a disproportionate number of low-income patients, its DRG revenues for inpatient operating costs are increased by an adjustment factor as specified in paragraph (d)(2) of this section.

(2) *Payment adjustment factors.* (i) If the hospital meets the criteria of paragraph (c)(1)(i) of this section, the payment adjustment factor is equal to one of the following:

(A) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is as follows:

(1) For discharges occurring on or after April 1, 1990, and before January 1, 1991, 5.62 percent plus 65 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(2) For discharges occurring on or after January 1, 1991, and before October 1, 1993, 5.62 percent plus 70 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(3) For discharges occurring on or after October 1, 1993, and before October 1, 1994, 5.88 percent plus 80 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(4) For discharges occurring on or after October 1, 1994, 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(B) If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is as follows:

(1) For discharges occurring on or after April 1, 1990, and before October 1, 1993, 2.5 percent plus 60 percent of the

difference between 15 percent and the hospital's disproportionate patient percentage.

(2) For discharges occurring on or after October 1, 1993, 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(ii) If the hospital meets the criteria of paragraph (c)(1)(ii) of this section, the payment adjustment factor is equal to one of the following:

(A) If the hospital is classified as a rural referral center, the payment adjustment factor is 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent.

(B) If the hospital is classified as a sole community hospital, the payment adjustment factor is 10 percent.

(C) If the hospital is classified as both a rural referral center and a sole community hospital, the payment adjustment factor is the greater of 10 percent or 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent.

(D) If the hospital is not classified as either a sole community hospital or a rural referral center, the payment adjustment factor is 4 percent.

(iii) If the hospital meets the criteria of paragraph (c)(1)(iii) of this section, the payment adjustment factor is equal to 5 percent.

(iv) If the hospital meets the criteria of paragraph (c)(1)(iv) of this section, the payment adjustment factor is 4 percent.

(v) If the hospital meets the criteria of paragraph (c)(2) of this section, the payment adjustment factor is as follows:

(A) 30 percent for discharges occurring on or after April 1, 1990 and before October 1, 1991.

(B) 35 percent for discharges occurring on or after October 1, 1991.

(e) *Reduction in payments for FYs 1998 through 2002.* The amounts otherwise payable to a hospital under paragraph (d) of this section are reduced by the following:

(1) For FY 1998, 1 percent.

(2) For FY 1999, 2 percent.

(3) For FY 2000, 3 percent.

(4) For FY 2001, 4 percent.

(5) For FY 2002, 5 percent.

(6) For FYs 2003 and thereafter, 0 percent.

[54 FR 36494, Sept. 1, 1989, as amended at 55 FR 14283, Apr. 17, 1990; 55 FR 15174, Apr. 20, 1990; 55 FR 32088, Aug. 7, 1990; 56 FR 573, Jan. 7, 1991; 56 FR 9633, Mar. 7, 1991; 57 FR 39824, Sept. 1, 1992; 60 FR 45848, Sept. 1, 1995; 62 FR 46029, Aug. 29, 1997]

**§ 412.107 Special treatment: Hospitals that receive an additional update for FYs 1998 and 1999.**

(a) *Additional payment update.* A hospital that meets the criteria set forth in paragraph (b) of this section receives the following increase to its applicable percentage amount set forth in § 412.63 (p) and (q):

(1) For FY 1998, 0.5 percent.

(2) For FY 1999, 0.3 percent.

(b) *Criteria for classification.* A hospital is eligible for the additional payment update set forth in paragraph (a) of this section if it meets all of the following criteria:

(1) *Definition.* The hospital is not a Medicare-dependent, small rural hospital as defined in § 412.108(a) and does not receive any additional payment under the following provisions:

(i) The indirect medical education adjustment made under § 412.105.

(ii) The disproportionate share adjustment made under § 412.106.

(2) *State criteria.* The hospital is located in a State in which the aggregate payment made under § 412.112 (a) and (c) for hospitals described in paragraph (b)(1) of this section for their cost reporting periods beginning in FY 1995 is less than the allowable operating costs described in § 412.2(c) for those hospitals.

(3) *Hospital criteria.* The aggregate payment made to the hospital under § 412.112 (a) and (c) for the hospital's cost reporting period beginning in the fiscal year in which the additional payment update described in paragraph (a) of this section is made is less than the allowable operating cost described in § 412.2(c) for that hospital.

[62 FR 46030, Aug. 29, 1997]

**§ 412.108 Special treatment: Medicare-dependent, small rural hospitals.**

(a) *Criteria for classification as a Medicare-dependent, small rural hospital.* (1)

*General considerations.* For cost reporting periods beginning on or after April 1, 1990 and ending before October 1, 1994, or beginning on or after October 1, 1997 and ending before October 1, 2001, a hospital is classified as a Medicare-dependent, small rural hospital if it is located in a rural area (as defined in § 412.63(b)) and meets all of the following conditions:

(i) The hospital has 100 or fewer beds as defined in § 412.105(b) during the cost reporting period.

(ii) The hospital is not also classified as a sole community hospital under § 412.92.

(iii) At least 60 percent of the hospital's inpatient days or discharges were attributable to individuals receiving Medicare part A benefits during the hospital's cost reporting period as follows, subject to the provisions of paragraph (a)(1)(iv) of this section:

(A) The hospital's cost reporting period ending on or after September 30, 1987 and before September 30, 1988.

(B) If the hospital does not have a cost reporting period that meets the criterion set forth in paragraph (a)(1)(iii)(A) of this section, the hospital's cost reporting period beginning on or after October 1, 1986, and before October 1, 1987.

(iv) If the cost reporting period determined under paragraph (a)(1)(iii) of this section is for less than 12 months, the hospital's most recent 12-month or longer cost reporting period before the short period is used.

(2) *Counting days and discharges.* In counting inpatient days and discharges for purposes of meeting the criteria in paragraph (a)(1)(iii) of this section, only days and discharges from acute care inpatient hospital stays are counted (including days and discharges from swing beds when used for acute care inpatient hospital services), but not including days and discharges from units excluded from the prospective payment system under §§ 412.25 through 412.30 or from newborn nursery units. For purposes of this section, a transfer as defined in § 412.4(b) is considered to be a discharge.

(b) *Classification procedures.* The fiscal intermediary determines whether a hospital meets the criteria in paragraph (a) of this section. If a hospital